
ENGROSSED SUBSTITUTE SENATE BILL 5261

State of Washington

60th Legislature

2008 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser, Franklin, Kohl-Welles, Fairley, and Kline; by request of Insurance Commissioner)

READ FIRST TIME 01/25/08.

1 AN ACT Relating to granting the insurance commissioner the
2 authority to review individual health benefit plan rates; amending RCW
3 48.18.110, 48.44.020, 48.46.060, 48.20.025, 48.44.017, and 48.46.062;
4 and creating a new section.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 **Sec. 1.** RCW 48.18.110 and 2000 c 79 s 2 are each amended to read
7 as follows:

8 (1) The commissioner shall disapprove any such form of policy,
9 application, rider, or endorsement, or withdraw any previous approval
10 thereof, only:

11 (a) If it is in any respect in violation of or does not comply with
12 this code or any applicable order or regulation of the commissioner
13 issued pursuant to the code; or

14 (b) If it does not comply with any controlling filing theretofore
15 made and approved; or

16 (c) If it contains or incorporates by reference any inconsistent,
17 ambiguous or misleading clauses, or exceptions and conditions which
18 unreasonably or deceptively affect the risk purported to be assumed in
19 the general coverage of the contract; or

1 (d) If it has any title, heading, or other indication of its
2 provisions which is misleading; or

3 (e) If purchase of insurance thereunder is being solicited by
4 deceptive advertising.

5 (2) In addition to the grounds for disapproval of any such form as
6 provided in subsection (1) of this section, the commissioner may
7 disapprove any form of disability insurance policy(~~(, except an~~
8 ~~individual health benefit plan,~~)) if the benefits provided therein are
9 unreasonable in relation to the premium charged. Rates, or any
10 modification of rates, for individual health benefit plans may not be
11 used until sixty days after they are filed with the commissioner.

12 **Sec. 2.** RCW 48.44.020 and 2000 c 79 s 28 are each amended to read
13 as follows:

14 (1) Any health care service contractor may enter into contracts
15 with or for the benefit of persons or groups of persons which require
16 prepayment for health care services by or for such persons in
17 consideration of such health care service contractor providing one or
18 more health care services to such persons and such activity shall not
19 be subject to the laws relating to insurance if the health care
20 services are rendered by the health care service contractor or by a
21 participating provider.

22 (2) The commissioner may on examination, subject to the right of
23 the health care service contractor to demand and receive a hearing
24 under chapters 48.04 and 34.05 RCW, disapprove any individual or group
25 contract form for any of the following grounds:

26 (a) If it contains or incorporates by reference any inconsistent,
27 ambiguous or misleading clauses, or exceptions and conditions which
28 unreasonably or deceptively affect the risk purported to be assumed in
29 the general coverage of the contract; or

30 (b) If it has any title, heading, or other indication of its
31 provisions which is misleading; or

32 (c) If purchase of health care services thereunder is being
33 solicited by deceptive advertising; or

34 (d) If it contains unreasonable restrictions on the treatment of
35 patients; or

36 (e) If it violates any provision of this chapter; or

1 (f) If it fails to conform to minimum provisions or standards
2 required by regulation made by the commissioner pursuant to chapter
3 34.05 RCW; or

4 (g) If any contract for health care services with any state agency,
5 division, subdivision, board, or commission or with any political
6 subdivision, municipal corporation, or quasi-municipal corporation
7 fails to comply with state law.

8 (3) In addition to the grounds listed in subsection (2) of this
9 section, the commissioner may disapprove any group contract if the
10 benefits provided therein are unreasonable in relation to the amount
11 charged for the contract. Rates, or any modification of rates, for
12 individual health benefit plans may not be used until sixty days after
13 they are filed with the commissioner.

14 (4)(a) Every contract between a health care service contractor and
15 a participating provider of health care services shall be in writing
16 and shall state that in the event the health care service contractor
17 fails to pay for health care services as provided in the contract, the
18 enrolled participant shall not be liable to the provider for sums owed
19 by the health care service contractor. Every such contract shall
20 provide that this requirement shall survive termination of the
21 contract.

22 (b) No participating provider, agent, trustee, or assignee may
23 maintain any action against an enrolled participant to collect sums
24 owed by the health care service contractor.

25 **Sec. 3.** RCW 48.46.060 and 2000 c 79 s 31 are each amended to read
26 as follows:

27 (1) Any health maintenance organization may enter into agreements
28 with or for the benefit of persons or groups of persons, which require
29 prepayment for health care services by or for such persons in
30 consideration of the health maintenance organization providing health
31 care services to such persons. Such activity is not subject to the
32 laws relating to insurance if the health care services are rendered
33 directly by the health maintenance organization or by any provider
34 which has a contract or other arrangement with the health maintenance
35 organization to render health services to enrolled participants.

36 (2) All forms of health maintenance agreements issued by the
37 organization to enrolled participants or other marketing documents

1 purporting to describe the organization's comprehensive health care
2 services shall comply with such minimum standards as the commissioner
3 deems reasonable and necessary in order to carry out the purposes and
4 provisions of this chapter, and which fully inform enrolled
5 participants of the health care services to which they are entitled,
6 including any limitations or exclusions thereof, and such other rights,
7 responsibilities and duties required of the contracting health
8 maintenance organization.

9 (3) Subject to the right of the health maintenance organization to
10 demand and receive a hearing under chapters 48.04 and 34.05 RCW, the
11 commissioner may disapprove an individual or group agreement form for
12 any of the following grounds:

13 (a) If it contains or incorporates by reference any inconsistent,
14 ambiguous, or misleading clauses, or exceptions or conditions which
15 unreasonably or deceptively affect the risk purported to be assumed in
16 the general coverage of the agreement;

17 (b) If it has any title, heading, or other indication which is
18 misleading;

19 (c) If purchase of health care services thereunder is being
20 solicited by deceptive advertising;

21 (d) If it contains unreasonable restrictions on the treatment of
22 patients;

23 (e) If it is in any respect in violation of this chapter or if it
24 fails to conform to minimum provisions or standards required by the
25 commissioner by rule under chapter 34.05 RCW; or

26 (f) If any agreement for health care services with any state
27 agency, division, subdivision, board, or commission or with any
28 political subdivision, municipal corporation, or quasi-municipal
29 corporation fails to comply with state law.

30 (4) In addition to the grounds listed in subsection (2) of this
31 section, the commissioner may disapprove any (~~group~~) agreement if the
32 benefits provided therein are unreasonable in relation to the amount
33 charged for the agreement. Rates, or any modification of rates, for
34 individual health benefit plans may not be used until sixty days after
35 they are filed with the commissioner.

36 (5) No health maintenance organization authorized under this
37 chapter shall cancel or fail to renew the enrollment on any basis of an
38 enrolled participant or refuse to transfer an enrolled participant from

1 a group to an individual basis for reasons relating solely to age, sex,
2 race, or health status. Nothing contained herein shall prevent
3 cancellation of an agreement with enrolled participants (a) who violate
4 any published policies of the organization which have been approved by
5 the commissioner, or (b) who are entitled to become eligible for
6 medicare benefits and fail to enroll for a medicare supplement plan
7 offered by the health maintenance organization and approved by the
8 commissioner, or (c) for failure of such enrolled participant to pay
9 the approved charge, including cost-sharing, required under such
10 contract, or (d) for a material breach of the health maintenance
11 agreement.

12 (6) No agreement form or amendment to an approved agreement form
13 shall be used unless it is first filed with the commissioner.

14 **Sec. 4.** RCW 48.20.025 and 2003 c 248 s 8 are each amended to read
15 as follows:

16 (1) The definitions in this subsection apply throughout this
17 section unless the context clearly requires otherwise.

18 (a) "Claims" means the cost to the insurer of health care services,
19 as defined in RCW 48.43.005, provided to a policyholder or paid to or
20 on behalf of the policyholder in accordance with the terms of a health
21 benefit plan, as defined in RCW 48.43.005. This includes capitation
22 payments or other similar payments made to providers for the purpose of
23 paying for health care services for a policyholder.

24 (b) "Claims reserves" means: (i) The liability for claims which
25 have been reported but not paid; (ii) the liability for claims which
26 have not been reported but which may reasonably be expected; (iii)
27 active life reserves; and (iv) additional claims reserves whether for
28 a specific liability purpose or not.

29 (c) "Declination rate" for an insurer means the percentage of the
30 total number of applicants for individual health benefit plans received
31 by that insurer in the aggregate in the applicable year which are not
32 accepted for enrollment by that insurer based on the results of the
33 standard health questionnaire administered pursuant to RCW
34 48.43.018(2)(a).

35 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,
36 plus any rate credits or recoupments less any refunds, for the

1 applicable period, whether received before, during, or after the
2 applicable period.

3 ~~((d))~~ (e) "Incurred claims expense" means claims paid during the
4 applicable period plus any increase, or less any decrease, in the
5 claims reserves.

6 ~~((e))~~ (f) "Loss ratio" means incurred claims expense as a
7 percentage of earned premiums.

8 ~~((f))~~ (g) "Reserves" means: (i) Active life reserves; and (ii)
9 additional reserves whether for a specific liability purpose or not.

10 (2) ~~((An insurer shall file, for informational purposes only, a
11 notice of its schedule of rates for its individual health benefit plans
12 with the commissioner prior to use.~~

13 ~~(3))~~ An insurer ~~((shall))~~ must file ~~((with the notice required
14 under subsection (2) of this section))~~ supporting documentation of its
15 method of determining the rates charged~~((The commissioner may
16 request only))~~ for its individual health benefit plans. At a minimum,
17 the insurer must provide the following supporting documentation:

18 (a) A description of the insurer's rate-making methodology;

19 (b) An actuarially determined estimate of incurred claims which
20 includes the experience data, assumptions, and justifications of the
21 insurer's projection;

22 (c) The percentage of premium attributable in aggregate for
23 nonclaims expenses used to determine the adjusted community rates
24 charged; and

25 (d) A certification by a member of the American academy of
26 actuaries, or other person approved by the commissioner, that the
27 adjusted community rate charged can be reasonably expected to result in
28 a loss ratio that meets or exceeds the loss ratio standard
29 ~~((established in subsection (7) of this section))~~ of seventy-four
30 percent, minus the premium tax rate applicable to the insurer's
31 individual health benefit plans under RCW 48.14.020.

32 ~~((4) The commissioner may not disapprove or otherwise impede the
33 implementation of the filed rates.~~

34 ~~(5))~~ (3) By the last day of May each year any insurer issuing or
35 renewing individual health benefit plans in this state during the
36 preceding calendar year shall file for review by the commissioner
37 supporting documentation of its actual loss ratio and its actual
38 declination rate for its individual health benefit plans offered or

1 renewed in the state in aggregate for the preceding calendar year. The
2 filing shall include aggregate earned premiums, aggregate incurred
3 claims, and a certification by a member of the American academy of
4 actuaries, or other person approved by the commissioner, that the
5 actual loss ratio has been calculated in accordance with accepted
6 actuarial principles.

7 (a) At the expiration of a thirty-day period beginning with the
8 date the filing is received by the commissioner, the filing shall be
9 deemed approved unless prior thereto the commissioner contests the
10 calculation of the actual loss ratio.

11 (b) If the commissioner contests the calculation of the actual loss
12 ratio, the commissioner shall state in writing the grounds for
13 contesting the calculation to the insurer.

14 (c) Any dispute regarding the calculation of the actual loss ratio
15 shall, upon written demand of either the commissioner or the insurer,
16 be submitted to hearing under chapters 48.04 and 34.05 RCW.

17 ~~((+6+))~~ (4) If the actual loss ratio for the preceding calendar
18 year is less than the loss ratio established in subsection ~~((+7+))~~ (5)
19 of this section, a remittance is due and the following shall apply:

20 (a) The insurer shall calculate a percentage of premium to be
21 remitted to the Washington state health insurance pool by subtracting
22 the actual loss ratio for the preceding year from the loss ratio
23 established in subsection ~~((+7+))~~ (5) of this section.

24 (b) The remittance to the Washington state health insurance pool is
25 the percentage calculated in (a) of this subsection, multiplied by the
26 premium earned from each enrollee in the previous calendar year.
27 Interest shall be added to the remittance due at a five percent annual
28 rate calculated from the end of the calendar year for which the
29 remittance is due to the date the remittance is made.

30 (c) All remittances shall be aggregated and such amounts shall be
31 remitted to the Washington state high risk pool to be used as directed
32 by the pool board of directors.

33 (d) Any remittance required to be issued under this section shall
34 be issued within thirty days after the actual loss ratio is deemed
35 approved under subsection ~~((+5+))~~ (3)(a) of this section or the
36 determination by an administrative law judge under subsection ~~((+5+))~~
37 (3)(c) of this section.

1 ~~((7))~~ (5) The loss ratio applicable to this section shall be
 2 ~~((seventy-four percent))~~ the percentage set forth in the following
 3 schedule that correlates to the health care service contractor's actual
 4 declination rate in the preceding year, minus the premium tax rate
 5 applicable to the insurer's individual health benefit plans under RCW
 6 48.14.020.

| | | |
|----|---|------------------------------------|
| 7 | <u>Actual Declination Rate</u> | <u>Loss Ratio</u> |
| 8 | <u>Under Six Percent (6%)</u> | <u>Seventy-Four Percent (74%)</u> |
| 9 | <u>Six Percent (6%) or more (but less than Seven Percent)</u> | <u>Seventy-Five Percent (75%)</u> |
| 10 | <u>Seven Percent (7%) or more (but less than Eight Percent)</u> | <u>Seventy-Six Percent (76%)</u> |
| 11 | <u>Eight Percent (8%) or more</u> | <u>Seventy-Seven Percent (77%)</u> |

12 **Sec. 5.** RCW 48.44.017 and 2001 c 196 s 11 are each amended to read
 13 as follows:

14 (1) The definitions in this subsection apply throughout this
 15 section unless the context clearly requires otherwise.

16 (a) "Claims" means the cost to the health care service contractor
 17 of health care services, as defined in RCW 48.43.005, provided to a
 18 contract holder or paid to or on behalf of a contract holder in
 19 accordance with the terms of a health benefit plan, as defined in RCW
 20 48.43.005. This includes capitation payments or other similar payments
 21 made to providers for the purpose of paying for health care services
 22 for an enrollee.

23 (b) "Claims reserves" means: (i) The liability for claims which
 24 have been reported but not paid; (ii) the liability for claims which
 25 have not been reported but which may reasonably be expected; (iii)
 26 active life reserves; and (iv) additional claims reserves whether for
 27 a specific liability purpose or not.

28 (c) "Declination rate" for an insurer means the percentage of the
 29 total number of applicants for individual health benefit plans received
 30 by that insurer in the aggregate in the applicable year which are not
 31 accepted for enrollment by that insurer based on the results of the
 32 standard health questionnaire administered pursuant to RCW
 33 48.43.018(2)(a).

34 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,
 35 plus any rate credits or recoupments less any refunds, for the

1 applicable period, whether received before, during, or after the
2 applicable period.

3 ~~((d))~~ (e) "Incurred claims expense" means claims paid during the
4 applicable period plus any increase, or less any decrease, in the
5 claims reserves.

6 ~~((e))~~ (f) "Loss ratio" means incurred claims expense as a
7 percentage of earned premiums.

8 ~~((f))~~ (g) "Reserves" means: (i) Active life reserves; and (ii)
9 additional reserves whether for a specific liability purpose or not.

10 (2) ~~((A health care service contractor shall file, for
11 informational purposes only, a notice of its schedule of rates for its
12 individual contracts with the commissioner prior to use.~~

13 ~~(3))~~ A health care service contractor ~~((shall))~~ must file ~~((with
14 the notice required under subsection (2) of this section))~~ supporting
15 documentation of its method of determining the rates charged~~((The
16 commissioner may request only))~~ for its individual contracts. At a
17 minimum, the health care service contractor must provide the following
18 supporting documentation:

19 (a) A description of the health care service contractor's rate-
20 making methodology;

21 (b) An actuarially determined estimate of incurred claims which
22 includes the experience data, assumptions, and justifications of the
23 health care service contractor's projection;

24 (c) The percentage of premium attributable in aggregate for
25 nonclaims expenses used to determine the adjusted community rates
26 charged; and

27 (d) A certification by a member of the American academy of
28 actuaries, or other person approved by the commissioner, that the
29 adjusted community rate charged can be reasonably expected to result in
30 a loss ratio that meets or exceeds the loss ratio standard
31 ~~((established in subsection (7) of this section))~~ of seventy-four
32 percent, minus the premium tax rate applicable to the insurer's
33 individual health benefit plans under RCW 48.14.020.

34 ~~((4) The commissioner may not disapprove or otherwise impede the
35 implementation of the filed rates.~~

36 ~~(5))~~ (3) By the last day of May each year any health care service
37 contractor issuing or renewing individual health benefit plans in this
38 state during the preceding calendar year shall file for review by the

1 commissioner supporting documentation of its actual loss ratio and its
2 actual declination rate for its individual health benefit plans offered
3 or renewed in this state in aggregate for the preceding calendar year.
4 The filing shall include aggregate earned premiums, aggregate incurred
5 claims, and a certification by a member of the American academy of
6 actuaries, or other person approved by the commissioner, that the
7 actual loss ratio has been calculated in accordance with accepted
8 actuarial principles.

9 (a) At the expiration of a thirty-day period beginning with the
10 date the filing is received by the commissioner, the filing shall be
11 deemed approved unless prior thereto the commissioner contests the
12 calculation of the actual loss ratio.

13 (b) If the commissioner contests the calculation of the actual loss
14 ratio, the commissioner shall state in writing the grounds for
15 contesting the calculation to the health care service contractor.

16 (c) Any dispute regarding the calculation of the actual loss ratio
17 shall upon written demand of either the commissioner or the health care
18 service contractor be submitted to hearing under chapters 48.04 and
19 34.05 RCW.

20 ~~((+6+))~~ (4) If the actual loss ratio for the preceding calendar
21 year is less than the loss ratio standard established in subsection
22 ~~((+7+))~~ (5) of this section, a remittance is due and the following
23 shall apply:

24 (a) The health care service contractor shall calculate a percentage
25 of premium to be remitted to the Washington state health insurance pool
26 by subtracting the actual loss ratio for the preceding year from the
27 loss ratio established in subsection ~~((+7+))~~ (5) of this section.

28 (b) The remittance to the Washington state health insurance pool is
29 the percentage calculated in (a) of this subsection, multiplied by the
30 premium earned from each enrollee in the previous calendar year.
31 Interest shall be added to the remittance due at a five percent annual
32 rate calculated from the end of the calendar year for which the
33 remittance is due to the date the remittance is made.

34 (c) All remittances shall be aggregated and such amounts shall be
35 remitted to the Washington state high risk pool to be used as directed
36 by the pool board of directors.

37 (d) Any remittance required to be issued under this section shall
38 be issued within thirty days after the actual loss ratio is deemed

1 approved under subsection ~~((+5))~~ (3)(a) of this section or the
2 determination by an administrative law judge under subsection ~~((+5))~~
3 (3)(c) of this section.

4 ~~((+7))~~ (5) The loss ratio applicable to this section shall be
5 ~~((seventy-four percent))~~ the percentage set forth in the following
6 schedule that correlates to the health care service contractor's actual
7 declination rate in the preceding year, minus the premium tax rate
8 applicable to the health care service contractor's individual health
9 benefit plans under RCW 48.14.0201.

| <u>Actual Declination Rate</u> | <u>Loss Ratio</u> |
|---|------------------------------------|
| <u>Under Six Percent (6%)</u> | <u>Seventy-Four Percent (74%)</u> |
| <u>Six Percent (6%) or more (but less than Seven Percent)</u> | <u>Seventy-Five Percent (75%)</u> |
| <u>Seven Percent (7%) or more (but less than Eight Percent)</u> | <u>Seventy-Six Percent (76%)</u> |
| <u>Eight Percent (8%) or more</u> | <u>Seventy-Seven Percent (77%)</u> |

15 **Sec. 6.** RCW 48.46.062 and 2001 c 196 s 12 are each amended to read
16 as follows:

17 (1) The definitions in this subsection apply throughout this
18 section unless the context clearly requires otherwise.

19 (a) "Claims" means the cost to the health maintenance organization
20 of health care services, as defined in RCW 48.43.005, provided to an
21 enrollee or paid to or on behalf of the enrollee in accordance with the
22 terms of a health benefit plan, as defined in RCW 48.43.005. This
23 includes capitation payments or other similar payments made to
24 providers for the purpose of paying for health care services for an
25 enrollee.

26 (b) "Claims reserves" means: (i) The liability for claims which
27 have been reported but not paid; (ii) the liability for claims which
28 have not been reported but which may reasonably be expected; (iii)
29 active life reserves; and (iv) additional claims reserves whether for
30 a specific liability purpose or not.

31 (c) "Declination rate" for an insurer means the percentage of the
32 total number of applicants for individual health benefit plans received
33 by that insurer in the aggregate in the applicable year which are not
34 accepted for enrollment by that insurer based on the results of the
35 standard health questionnaire administered pursuant to RCW
36 48.43.018(2)(a).

1 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,
2 plus any rate credits or recoupments less any refunds, for the
3 applicable period, whether received before, during, or after the
4 applicable period.

5 ~~((d))~~ (e) "Incurred claims expense" means claims paid during the
6 applicable period plus any increase, or less any decrease, in the
7 claims reserves.

8 ~~((e))~~ (f) "Loss ratio" means incurred claims expense as a
9 percentage of earned premiums.

10 ~~((f))~~ (g) "Reserves" means: (i) Active life reserves; and (ii)
11 additional reserves whether for a specific liability purpose or not.

12 ~~(2) ((A health maintenance organization shall file, for
13 informational purposes only, a notice of its schedule of rates for its
14 individual agreements with the commissioner prior to use.~~

15 ~~(3))~~ A health maintenance organization ~~((shall))~~ must file ~~((with
16 the notice required under subsection (2) of this section))~~ supporting
17 documentation of its method of determining the rates charged~~((The
18 commissioner may request only))~~ for its individual agreements. At a
19 minimum, the health maintenance organization must provide the following
20 supporting documentation:

21 (a) A description of the health maintenance organization's rate-
22 making methodology;

23 (b) An actuarially determined estimate of incurred claims which
24 includes the experience data, assumptions, and justifications of the
25 health maintenance organization's projection;

26 (c) The percentage of premium attributable in aggregate for
27 nonclaims expenses used to determine the adjusted community rates
28 charged; and

29 (d) A certification by a member of the American academy of
30 actuaries, or other person approved by the commissioner, that the
31 adjusted community rate charged can be reasonably expected to result in
32 a loss ratio that meets or exceeds the loss ratio standard
33 ~~((established in subsection (7) of this section))~~ of seventy-four
34 percent, minus the premium tax rate applicable to the insurer's
35 individual health benefit plans under RCW 48.14.020.

36 ~~((4) The commissioner may not disapprove or otherwise impede the
37 implementation of the filed rates.~~

1 ~~(5)~~) (3) By the last day of May each year any health maintenance
2 organization issuing or renewing individual health benefit plans in
3 this state during the preceding calendar year shall file for review by
4 the commissioner supporting documentation of its actual loss ratio and
5 its actual declination rate for its individual health benefit plans
6 offered or renewed in the state in aggregate for the preceding calendar
7 year. The filing shall include aggregate earned premiums, aggregate
8 incurred claims, and a certification by a member of the American
9 academy of actuaries, or other person approved by the commissioner,
10 that the actual loss ratio has been calculated in accordance with
11 accepted actuarial principles.

12 (a) At the expiration of a thirty-day period beginning with the
13 date the filing is received by the commissioner, the filing shall be
14 deemed approved unless prior thereto the commissioner contests the
15 calculation of the actual loss ratio.

16 (b) If the commissioner contests the calculation of the actual loss
17 ratio, the commissioner shall state in writing the grounds for
18 contesting the calculation to the health maintenance organization.

19 (c) Any dispute regarding the calculation of the actual loss ratio
20 shall, upon written demand of either the commissioner or the health
21 maintenance organization, be submitted to hearing under chapters 48.04
22 and 34.05 RCW.

23 ~~((6))~~ (4) If the actual loss ratio for the preceding calendar
24 year is less than the loss ratio standard established in subsection
25 ~~((7))~~ (5) of this section, a remittance is due and the following
26 shall apply:

27 (a) The health maintenance organization shall calculate a
28 percentage of premium to be remitted to the Washington state health
29 insurance pool by subtracting the actual loss ratio for the preceding
30 year from the loss ratio established in subsection ~~((7))~~ (5) of this
31 section.

32 (b) The remittance to the Washington state health insurance pool is
33 the percentage calculated in (a) of this subsection, multiplied by the
34 premium earned from each enrollee in the previous calendar year.
35 Interest shall be added to the remittance due at a five percent annual
36 rate calculated from the end of the calendar year for which the
37 remittance is due to the date the remittance is made.

1 (c) All remittances shall be aggregated and such amounts shall be
2 remitted to the Washington state high risk pool to be used as directed
3 by the pool board of directors.

4 (d) Any remittance required to be issued under this section shall
5 be issued within thirty days after the actual loss ratio is deemed
6 approved under subsection ~~((+5+))~~ (3)(a) of this section or the
7 determination by an administrative law judge under subsection ~~((+5+))~~
8 (3)(c) of this section.

9 ~~((+7+))~~ (5) The loss ratio applicable to this section shall be
10 ~~((seventy-four percent))~~ the percentage set forth in the following
11 schedule that correlates to the health maintenance organization's
12 actual declination rate in the preceding year, minus the premium tax
13 rate applicable to the health maintenance organization's individual
14 health benefit plans under RCW 48.14.0201.

| <u>Actual Declination Rate</u> | <u>Loss Ratio</u> |
|---|------------------------------------|
| <u>Under Six Percent (6%)</u> | <u>Seventy-Four Percent (74%)</u> |
| <u>Six Percent (6%) or more (but less than Seven Percent)</u> | <u>Seventy-Five Percent (75%)</u> |
| <u>Seven Percent (7%) or more (but less than Eight Percent)</u> | <u>Seventy-Six Percent (76%)</u> |
| <u>Eight Percent (8%) or more</u> | <u>Seventy-Seven Percent (77%)</u> |

20 NEW SECTION. **Sec. 7.** The insurance commissioner's ability to
21 review and disapprove rates for individual products, as established in
22 sections 1 through 6 of this act, expires January 1, 2012.

--- END ---